TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Elite Healthcare Fort Worth

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-15-4195-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 27, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "All other claims have been paid at 100%. Therefore, these claims should be paid in full."

Amount in Dispute: $227.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In order to resolve this fee reimbursement dispute Texas Mutual Insurance Company has elected to pay the disputed service of 2/3/15. Texas Mutual paid previously disputed code 99213."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 20 & February 3, 2015	Evaluation & Management, established patient (99213)	$227.42	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-18 – Exact duplicate claim/service
   - 224 – Duplicate charge.
   - CAC-150 – Payer deems the information submitted does not support this level of service.
   - 864 – E/M services may be reported only if the patient's condition requires a significant separately identifiable E/M service.

- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 891 – No additional payment after reconsideration
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 920 – Reimbursement is being allowed based upon a dispute.

Issues

Is the requestor entitled to additional reimbursement?

Findings

The requestor is seeking reimbursement for date of service January 20, 2015, CPT code 99213 and date of service February 3, 2015, CPT code 99213 for a total of $227.42. The Explanation of Benefits from the insurance carrier dated February 25, 2015 indicates that CPT code 99213 for date of service January 20, 2015 was paid at $113.71. The Explanation of Benefits from the insurance carrier dated September 16, 2015 indicates that CPT code 99213 for date of service February 3, 2015 was paid at $113.71. The total amount paid by the insurance carrier for the disputed services is $227.42. No further reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	November 3, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.